

**IN-HOME SUPPORTIVE SERVICES PROGRAM  
NOTICE OF PROVIDER INELIGIBILITY****COUNTY OF****(ADDRESSEE)**

Notice Date: \_\_\_\_\_

Provider Name: \_\_\_\_\_

IHSS Office Address: \_\_\_\_\_

IHSS Office Telephone Number: \_\_\_\_\_

To: In-Home Supportive Services (IHSS) Provider Applicant

The county has found that you are not eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing services. Here's why:

As part of the provider enrollment process, you submitted fingerprints and went through a criminal background check by the California Department of Justice. The background check showed that you had been convicted of a crime(s) that makes you ineligible to be an IHSS provider and to receive payment from the IHSS Program for providing services. The crime(s) which disqualified you is/are shown below:

If you disagree with this decision, the back of this page explains how you can request an appeal. You must submit your appeal request within 60 calendar days from the date of this letter.

If you have any questions about this letter, you may call \_\_\_\_\_ .